Care Coordinator
Title V
Position Description

A. Care Management is a process that increases the likelihood that a patient will receive easily accessible, coordinated, continuous, high quality health care across all settings, including home. Care Management uses evidence-based medicine and best practices, technology, health education materials, nursing and other clinical disciplines' expertise, to manage the health care process and limit the inappropriate use of health care services.

B. A Care Coordinator is a professional who coordinates care for a panel of patients throughout the continuum of care to assure that care is timely, appropriate, of high quality and cost effective. A Care Coordinator works closely with the primary care provider (or providers) and other healthcare professionals and team members, other clinics, internal or external services and community agencies. He/she provides professional assessment, coordination and planning of multiple health care services; acts on behalf of the veteran to assure that necessary clinical services are received and that progress is being made. In addition the Care Coordinator provides ongoing evaluation of care management services.

Major Duties:

1. The incumbent provides professional assessment to an adult population of predominantly older, male patients.

2. The individual must demonstrate the knowledge of age-related factors, changes associated with aging and possess the ability to provide care as noted in age-specific competencies described in network and station policies and procedures. The Care Coordinator especially focuses on the patient in the context of family, home and community by integrating an assessment of living conditions, individual, family dynamics, and cultural background into the patient s plan of care.

3. The Care Coordinator is responsible for coordinating the appropriate intensity of care management for his/her panel. It is recognized that manageable panel sizes will vary depending on the case-mix of the panel. Care management is focused primarily on providing more coordinated and higher quality care to complex clinical cases with a goal of reducing the cost.

4. The Care Coordinator provides and coordinates services by assessing the needs of the client and the clients family. When appropriate, arranges, coordinates, monitors, evaluates,, and advocates for a package of multiple services to meet the specific client' s complex needs.

5. Care Management Services are carried out in full accordance with the broad program

goals of the VA health care system. Within these broad categorizations, the Care Coordinator must assess and tailor patient care/support services. Through assessment of each veteran's needs, he/she then facilitate the delivery of services that are most responsive to the concerns of individual patients to the extent possible.

6. The Care Coordinator establishes methods for tracking patients' progress, evaluating effectiveness of care, and maintains appropriate documentation of each patient's care and progress within the plan.

Factor 1. Knowledge required by the Position

A. The employee must be able to demonstrate the knowledge and skills necessary to provide care appropriate to the age and complexity of the patients served in his/her assigned service area.

B. The individual must demonstrate knowledge of the changes associated with aging and the principles of growth and development relevant to the adult and geriatric patient group. Incumbent must have knowledge and the ability to apply developmental theory and age specific issues.

C. He or she must be able to access and interpret data about the patient's social, emotional, mental health, medical needs and coordinate the care/services needed.

D. The incumbent must have knowledge of the vast array of VA, federal, state and local community agencies and resources and how to access and coordinate those services.

E. The incumbent must be able to demonstrate the knowledge and skills as identified in the Competency Assessment Checklist developed for this position.

F. The incumbent must demonstrate knowledge and skills in interpersonal relations. This includes the ability to appropriately, professionally and courteously relate to internal and external customers.

G. The incumbent must demonstrate the knowledge and skills to complete job assignments and safely and correctly operate equipment necessary to complete the duties of the position.

H. The incumbent is required to meet minimum OPM Qualification Standards for General Schedule Positions and/or VA Qualification Standards, MP-5, Part 1, Chapter 338.

I. The incumbent has knowledge of population characteristics including cultural, ethnic, gender, and religious diversity. He/she must have knowledge of family dynamics, psychotherapy, developmental theory and interpersonal relationships and systems approach to clinical care.

J. Incumbent maintain knowledge about disease processes, disabilities, medications and their clinical sequalae.

K. Incumbent participates in regular peer review and performance improvement activities.

L. Incumbent may serve as a preceptor or field instructor for students at the undergraduate, graduate or doctoral level.

M. Incumbent must have knowledge of current VA and non-VA entitlements and benefits. Must have knowledge of terminal illness and end of life planning processes.

N. Incumbent must have knowledge of medical, legal and ethical issues.

Factor 2. Supervisory Controls

A. Supervision is of a consultative nature and is usually arranged at the Care Coordinator s request to seek assistance with unusually complicated direct service work and for clarification of administrative issues. In the performance of the majority of activities, the incumbent exercises independent professional judgment working in the context of a multidisciplinary or interdisciplinary team. This ability is required to make independent decisions when working with the primary care team/provider while remaining an advocate for the patient/family.

B. The Care Coordinator is programmatically responsible to the designated program oversight for the local medical center in accordance with station level assignment.

C. Annual performance evaluation will be a collaborative effort between the employee and the station level supervisor with additional input from the VISN Care Coordination Program Manager as appropriate.

Factor 3. Guidelines

A. Incumbent is guided by VA Headquarters' directives, centralized network product line policies, bulletins, procedures, and supervisory instructions.

B. Highly developed professional skills, flexibility, mature professional judgment, and knowledge of a variety of advanced treatment modalities are required to make assessments and to intervene in complex and emergent case situations.

Factor 4. Complexity

In performing his/her duties, the incumbent works with clients whose socioeconomic

and health-related problems vary in complexity. Because the level of difficulty frequently cannot be determined prior to the Care Coordinators involvement in individual cases, the incumbent must independently make sound treatment decisions based on assessments, sometimes utilizing standardized assessment tools, and skillfully execute interventions for the most difficult cases.

In all cases, the Care Coordinator must make accurate and ongoing assessments of the patient' s clinical and social problems and needs, and be aware of procedures to support the veteran physically and financially in the community. The incumbent must be i~ble to effectively work with clients and families. The Care Coordinator provides assistance, information and support to patients/families in coping with emotional, practical and lifestyle issues, which accompany advancing age and physical, sensory, and cognitive impairments. He/she assists with development of processes to coordinate care along the continuum encouraging exploration of creative alternatives for care, enhancing communication with others, and helps to screen for problems that should be brought to the attention of the primary care provider. Assessment skills are appropriately utilized while articulating to members of the primary care team the needs of the patient. Initiative is taken to monitor appropriate level of care and length of stay in acute care to ensure cost effective care. While cost is a consideration, the overall goal of the Care Coordinator is to assure that the patient has the appropriate level of care and services to meet the social and health care needs. 'The incumbent may also perform a variety of mediating roles in promoting effective and efficient use of treatment services and the health care system.

Factor 5. Scope and Effect

The Care Coordinator is responsible for coordinating the development and implementing of the biopsychosocial treatment plan in collaboration with the primary care team/provider, across all settings, including the home. This responsibility requires considerable expertise and skill, as well as maintenance of an effective balance between the needs of the patients and families and the priorities of the Medical Center, the Sunshine Network and the VA health care system. The challenge of this assignment lies in skillfully developing an effective biopsychosocial treatment plan for patients who are seriously compromised by chronic illness, mental health, social, financial and other related conditions. The consequences of the actions taken may be serious because the veteran may be in an especially vulnerable position due to cognitive, sensory and functional impairments.

Factor 6. Personal Contacts

The incumbent must continually relate in a professional manner to primary care providers, members of the interdisciplinary team, as well as to patients, family members, students in training, representatives of various community agencies, and other medical center administrators and employees. In those contacts and in every-day decisions, the incumbent is expected to perform effectively in the absence of

immediate access to a supervisor.

Factor 7. Purpose of Contacts

The Care Coordinator must assess the provision of individual, family and group treatment; consult and plan with the interdisciplinary team; provide information to community agencies and inform supervisory staff of patient care activities. He/she also supervises/evaluates aspects of care provided by non-VA providers.

Factor 8. Physical Demands

The work requires some walking, standing, bending, and carrying of light items such as books, papers and laptop computers. Community visits will require the ability to drive a vehicle.

Factor 9. Work Environment

The incumbent will see veterans in a variety of treatment settings, such as group therapy rooms, inpatient wards, outpatient treatment rooms, and patients' ownhomes. The Incumbent abides by VA safety rules and regulations, and promotes safe behavior within the work environment and among co-workers. Position will require travel outside the Medical Center.